INQUIRY HELD UNDER FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976 INTO THE DEATH OF FRANCES CARVILL v.

SHERIFFDOM of TAYSIDE CENTRAL & FIFE

DETERMINATION

by

ROBERT ALASTAIR DUNLOP, QUEEN'S COUNSEL, Sheriff Principal of the Sheriffdom of Tayside Central and Fife following an INQUIRY held at Stirling on 8th, 12th and 13th March 2002 into the death of

FRANCES CARVILL

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STIRLING, 2 April 2002. The Sheriff Principal, having considered all the evidence adduced, Determines:-

- In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, that Frances Carvill, born 2nd October 1963, died on 29th October 2001 at 1230 hours in Stirling Royal Infirmary as a result of the consequences of hanging herself in the bathroom area of Unit 8, Peebles House, HM Prison, Cornton Vale, Stirling between the hours of 0945 and 1025 on 26th October 2001.
- In terms of Section 6(1)(b) of the said Act, that the cause of Frances Carvill's death was hanging by the neck.

NOTE:

- **Parties Represented at the Inquiry**

In this Inquiry evidence was presented on behalf of the Procurator Fiscal by his Depute Miss Orr. Mr Mowat, Solicitor, appeared for the Prison Officers Association Scotland and certain prison officers cited as witnesses; Mr Watson, Solicitor, appeared for Dr. Sayers; and Mr Lindsay, Advocate, appeared for the Scottish Prison Service. The family of Frances Carvill was not represented and no evidence was led from any relative of hers. I was informed by the Procurator Fiscal Depute however that she had been in contact with some members of the family and they had been made aware of the circumstances that had been disclosed by her investigations. Evidence was heard on 8th 12th and 13th March 2002.

2. Legal Framework

The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides that a public Inquiry should be held into the death of any person held in legal custody. The

reasons for making such Inquiry compulsory are obvious. It is clearly appropriate that, where somebody has been deprived of his or her freedom by legal process and then dies while in custody, a Court should investigate the circumstances of the death in public.

The purpose of the Inquiry is defined in Section 6(1) of the Act which is in the following terms:-

"At the conclusion of the evidence and any submissions thereon .... the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction-

(a)where and when the death and any accident resulting in the death took place;

- the cause or causes of such death and any accident resulting in the death;
- the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
- any other facts which are relevant to the circumstances of the death."

In terms of the Act the Procurator Fiscal has the responsibility in the public interest of investigating the circumstances of the death and placing before the court evidence bearing upon those circumstances. This procedure accordingly allows the circumstances surrounding a death to be brought under judicial and public scrutiny. It should be emphasised however that the Sheriff shall make a determination in relation to each of the matters in Section 6(1) only so far as the circumstances have been established to his satisfaction. The Court can only proceed on the basis of the evidence placed before it and should not speculate about whether other circumstances exist which have not been raised in the evidence. Having said that, there was nothing to indicate that the investigations of the Procurator Fiscal had been anything other than thorough. Nevertheless it is with these considerations in mind that I have confined my determination to the circumstances set out in Section 6(1)(a) and (b), a course of action urged upon me by all parties to the Inquiry.

3. The Context of the Inquiry

The death of Frances Carvill was the second death at HMP Cornton Vale within a period of days and that circumstance, when set against a background of a spate of suicides at this prison in the mid 1990s, may be thought to give rise to public concern. This Fatal Accident Inquiry was held immediately following the Inquiry into the death of the other prisoner and, as one might expect, the evidence in each had many common features, not least in relation to the Suicide Risk Management Strategy in operation at the prison. This strategy was introduced in about 1998 and represented a change of approach which, so far as the evidence discloses, sets the two deaths under consideration in a different context to that which surrounds the earlier deaths in the 1990s. Each Inquiry has been conducted separately and, despite the common features in the evidence, my determination falls to be made in relation to the evidence led regarding each death separately.

4. Factual Circumstances

The evidence led at the Inquiry gave rise to little controversy. The key facts were as follows.

On 7th July 1993 Frances Carvill was sentenced to life imprisonment for murder and was thereafter detained in HM Prison, Cornton Vale. She was the mother of three children. She had a history of drug abuse and both before and after her imprisonment her children were cared for by the local authority in terms of a supervision requirement of the children's hearing. She remained very attached to her children and during her sentence there were regular, mainly weekly, periods of contact between them.

According to the evidence of the prison medical officer, Dr Sayers, Frances Carvill suffered from a severe personality disorder. There was no psychiatric evidence to this effect and it was not a diagnosis that Dr Sayers was qualified to make. Nevertheless, this diagnosis was evident from the medical records relating to Frances Carvill, which Dr Sayers had reviewed and which were subject to his oversight. It was a characteristic of her disorder that Frances Carvill could behave in an impulsive and manipulative manner. Her condition gave rise to a chronic risk of self-harm and during the eight years of her detention in Cornton Vale she had harmed herself on several occasions.

The Scottish Prison Service has a Suicide Risk Management Strategy called "Act and Care" (hereinafter referred to as the "Act Strategy"), which was introduced in about 1998. The key aim of the strategy is -

"To assume a shared responsibility for the care of those "at risk" of self-harm or suicide. To work together to provide a caring environment where prisoners who are in distress can ask for help to avert a crisis. To identify need and offer assistance in advance, during and after a crisis."

The strategy identifies (a) groups of prisoners who are more likely to harm themselves, (b) events or triggers that might make self harm or suicide more likely and (c) non verbal and verbal signs that might be found in a particular prisoner which may indicate a risk of self-harm. (Production 9 pages 14 and 15). The strategy is aimed at reducing the risk of self-harm or suicide, but it is recognised that not all suicides are preventable.

All prison staff receive training in the operation of the Act Strategy, both at their induction to the Prison Service and on annual refresher courses and it was clear from the evidence that the scope of the strategy and the manner of its operation were well understood. Furthermore it was clear that the strategy was also well understood by the prisoners, who knew that they could themselves seek the protection of it, as indeed Frances Carvill did not long before her death.

In the event that a prisoner is identified as being at risk she will be made subject to the Act Strategy and to a number of measures intended to prevent self-harm. The nature of the measures will vary according to the assessed degree of risk but in most

cases will involve increased regular observation of the prisoner, which in extreme cases can involve a 24 hour guard.

There are a number of different residential blocks at HMP, Cornton Vale, one of which is Peebles House. Peebles House is used for category C and D prisoners. The regime of Peebles House is more relaxed than that of other residential blocks within the Prison. Prisoners are accorded a greater freedom of movement within the block. There is minimal supervision and no formal patrolling by prison officers. The aim of Peebles House is to place increased responsibility on the prisoners as a means of preparing them for release into the community at the end of their sentence. There is a high degree of trust placed in the prisoners. Such a regime is incompatible with the observation of prisoners subject to the Act Strategy and for that reason any prisoners that are placed on Act are relocated in other parts of the Prison. At the time of her death Frances Carvill was resident in Peebles House, although from 14th to 17th October 2001 she had been relocated to Younger House at her own request. During this period she had been made subject to the Act Strategy.

Frances Carvill was subject to the Act Strategy on various other occasions during her period of imprisonment and in particular had been subject to Act between 26th March and 18th May 2001, following an episode of self-harm. Following this period she settled well, aided by the birth of a grandson, and made good progress over several months so far as her mental health was concerned. In the days leading up to 26th October 2001 however she had shown signs of being unsettled by a number of different issues. In common with others serving sentences of life imprisonment, she was waiting for a date to return to the High Court for an order to be made fixing a determinate period of her sentence that would require to be served before her release on licence could be considered. She had been upset at the suicide on 24th October of another prisoner whom she knew. She was also concerned about her family.

On 14th October she spoke to her personal officer, James Fleming, and told him she needed "time out" away from Peebles House. Mr Fleming was aware of her previous mental health problems and decided to refer her to the Health Centre, although he himself did not consider that at that time there was any cause for concern that she might harm herself or require to be subjected to the Act Strategy. Following this she was re-located to Younger House. Mr Fleming saw her again on 19th October after she had returned to Peebles House on 17th October. She seemed fine and she told him she was feeling a lot better.

On 17th October she was seen by the senior social worker, Elaine Corvi, who knew her well. She told Elaine Corvi that she had wanted to go back to Younger House because she was uptight because of the "lifers' review" and that she needed to speak to certain people. It appeared to Elaine Corvi that she was now feeling better for having talked to others and she gave no cause for concern.

On 25th October, the day following the death of another prisoner, Elaine Corvi went round the prison with the prison Chaplain. They were concerned to make themselves aware of prisoners' reaction to the death and to offer them support. At about 11 am they saw Frances Carvill. She appeared upset and was invited into the office where they spent 15-20 minutes with her. She said that she knew the other prisoner and

was upset and surprised that she had taken her own life. Following the interview Elaine Corvi did not consider that she needed to go on Act and there was nothing in her manner or demeanour which rang alarm bells concerning her safety.

At about breakfast time on 26th October Frances Carvill came to the office of Easton Robertson, the supervisor in Peebles House. Ms Robertson knew Frances Carvill well and was aware of her mental health problems and history of self-harm. At that time Ms Robertson was busy and unable to speak to her and asked her to come back to see her later.

At that time Frances Carvill was resident in Unit 8 of Peebles House. The residential officer for Unit 8 that day was Stewart Adair, who knew Frances Carvill well and had a good working relationship with her. On that morning he was responsible for ensuring that prisoners left for work. When Frances Carvill failed to turn up for the work party at
9.15 am he went to speak to her. She told him that she had a headache and a sore ear. Mr Adair was aware however that she had attended the Health Centre that morning and had not been certified as unfit for work. He told her that she would be put on a disciplinary report if she did not go to work and tried to cajole her into doing so. Eventually she agreed to join the work party. When she arrived at her work station she went straight up to the prison officer in charge, Senga Stalker, and asked her to put her on report as she was going back to the block sick. Senga Stalker took time to speak to her about her reasons for not wanting to work and tried to persuade her to stay. Frances Carvill however was adamant that she was not going to work and accordingly she was informed that she would be placed on report. It appeared to Senga Stalker that Frances Carvill was tired and pale and was irritated that the Health Centre would not allow her to go off work sick. Beyond this sign of irritation there was nothing that Senga Stalker noticed about her manner or demeanour which gave rise to any concern that she might attempt to harm herself. Following her interview with Senga Stalker, Frances Carvill returned to the block shortly after 0940 and was admitted by Stewart Adair. She seemed to him to be a bit angry but there was nothing in her demeanour to suggest that she might harm herself. Having been re-admitted to the block she went to her room.

Earlier in the morning Frances Carvill had been seen by a fellow prisoner Jane Reid with whom she had established a good relationship. Jane Reid was one of a number of prisoners who had been trained as a listener, that is to say a person who could befriend other prisoners and be an ear for them. Such prisoners received training, including training in counselling, from the Samaritans. When Jane Reid saw Frances Carvill she had been crying. She seemed generally fed up and did not want to go to work. Jane Reid was concerned and told her she would get dressed and come up to her room later. She did so after Frances Carvill had returned from the work party on report. Frances Carvill told Jane Reid that she was going for a bath and would come round to her unit when she was finished. When Jane Reid left at about 0945 she had no concerns for her wellbeing. Another prisoner in Unit 8, Ashley Keenan, heard her running the bath. Shortly after that, at about 1025, Ashley Keenan decided to have a bath herself and went into the bathroom area. She found Frances Carvill hanging in the bathroom. She ran down the stairs screaming. Her screams alerted prison officers James Fleming and Howard Sellick, who ran to the bathroom area in Unit 8 where they found Frances Carvill suspended by a ligature from bars at the window in

the bathroom. They raised the alarm and immediately supported her weight, while Mr Sellick forced the ligature over her head. They then lowered her to the floor and commenced resuscitation procedures. They checked for a pulse but could find none.

Shortly thereafter medical staff arrived in Unit 8 in response to the alarm. Frances Carvill was in cardiac arrest. Resuscitation procedures were continued. There was no vein available for intravenous injection and accordingly drugs required to be administered through a tube into the lungs. She was connected to a defibrillator. After five minutes some electrical activity was detected but this was abnormal. Thereafter she was conveyed by ambulance to Stirling Royal Infirmary.

On admission to Hospital Frances Carvill was found to be deeply unconscious. She was diagnosed as suffering from hypoxic brain injury following cardiac arrest. She was placed on a ventilator. Despite intensive treatment her condition deteriorated over the next few days. On 29th October 2001 repeat brain stem testing disclosed no brain stem activity and life was pronounced extinct at 1230 hours on that date. A post mortem examination was carried out on 30th October when it was discovered that there had been a failure of internal organs in keeping with a period of lack of oxygen to those organs. Death was certified as being caused by hanging by the neck.

5. Scope of Determination

In her submissions the Procurator Fiscal Depute contended that the evidence did not support the making of a determination beyond the circumstances outlined in paragraphs (a) and (b) of Section 6(1) and in my view that submission is well founded. This submission was adopted by each of those represented at the Inquiry. Notwithstanding that submission, the Procurator Fiscal Depute very properly led evidence relating to the operation of the Act Strategy, its effectiveness and the extent to which it was implemented and it is important that I should give some attention to that evidence.

It is clear from the evidence that Frances Carvill took her own life. The precise reasons for her doing so remain something of a mystery. The evidence suggests that, in the days leading up to her death, she was concerned about a number of matters, but whether these were factors leading to her decision to take her life is a matter of speculation. Her fellow prisoner, Jane Reid, whom I found to be an impressive witness, described Frances Carvill as having a generally depressed nature and to be quite a depressing person. Elaine Corvi echoed that assessment in her evidence that Frances Carvill was not an upbeat optimistic person. She also said that she had always given a clear indication if she felt suicidal and she was not slow to seek help if she felt that she needed it. Having been in prison for many years, she was well known to the staff and I was satisfied that I could rely on their assessments of her nature and patterns of behaviour. Although there was evidence of upset and even crying in the days preceding her death, it is significant that nobody saw any signs of behaviour which gave rise to a concern that Frances Carvill might harm herself. There was nothing to show any change in her normal underlying character and appearance.

The evidence demonstrated to my satisfaction that the Act Strategy was sound in principle and was well understood by the staff and indeed others, such as Jane Reid. Had there been any signs indicating that Frances Carvill was likely to try to harm herself I think it probable that these would have been manifest to at least some of those witnesses who had come into contact with her during the last few days of her life. She had had fairly extensive contact with a number of different members of staff and inmates and accordingly there was no lack of opportunity to pick up such signs if they existed. There is accordingly nothing in the evidence to suggest that the Act Strategy was not operated satisfactorily.

I have already referred to the evidence of Dr Sayers regarding Frances Carvill's personality disorder and history of self harm and an issue which arose in the course of the evidence was whether Frances Carvill should have been placed in the more liberal regime of Peebles House given that condition and history. There was no criticism of the regime as such and it seems entirely appropriate having regard to the purpose that it was seeking to achieve. In his evidence Dr Sayers recognised that Frances Carvill presented difficulties in terms of her appropriate management. A person with that diagnosis will always have the potential for self-harm. Her previous episodes of self-harm had not been related to any trigger that was predictable. Although she had been admitted to the State Hospital at Carstairs on three occasions, two of which were for management purposes, she had ultimately been assessed as unsuitable for admission there on a longer-term basis.

Against that background, Dr Sayers expressed the view that there was no ideal environment in which Frances Carvill could be cared for. In his view, even those with personality disorder need to be progressed through the system towards their eventual release and it is in their interests from a mental health point of view to try and achieve that progress. To keep a prisoner subject to the Act Strategy throughout what may be a lengthy prison sentence would probably have a negative effect on her mental health. There is accordingly always an element of concern at someone like Frances Carvill being placed in Peebles House, but the proper approach is to be more attentive to her presentation and to apply a lower threshold in considering whether to place her on Act at any particular time. Frances Carvill was seen by Dr Sayers on 25th October 2001 with a complaint of earache. At that time she was upset at the death of another prisoner, but was otherwise quite relaxed. Dr Sayers found nothing to suggest that she was at risk of self-harm. Like every other witness who had been trained in and operated the Act Strategy, he would have had no hesitation in putting her on Act if he thought that was necessary. I have no reason whatever to doubt that evidence.

There was no criticism of the approach advanced by Dr Sayers and in my view it is a reasonable and appropriate response to what is a hugely difficult issue of management. Clearly it is difficult to strike the right balance and there is a constant requirement to make judgments. Although her history of self-harm was a significant one, the evidence clearly supported the view that Frances Carvill had indeed made progress within the prison system. There had been a three-year period after about the middle of 1997 when there had been no episode of self-harm. The incidents of self-harm at the start of 2001 were seen by Dr Sayers as manipulative, following the decision not to admit her to the State Hospital at Carstairs. But even after that episode she had returned to making good progress and this had been commented

upon by a number of persons who knew her well. The Procurator Fiscal Depute submitted that, against that background, it was appropriate that Frances Carvill should have been put in Peebles House and thus subject to the more liberal regime that operated there. In my view that submission is well founded on the evidence that I have heard. The freedom of movement available to her however meant that there was nothing to prevent her taking the tragic course of action that she did. Whether that course of action was an impulsive act or one which had been planned for some time will never be known. All that can be said is that there was no objective sign of an intention to commit suicide and even shortly before her death she had told Jane Reid that she would see her after her bath.

In all these circumstances I agree with the submission of the Procurator Fiscal Depute that there is no basis for making any determination under Section 6(1)(c) and (d) of the Act and that my determination should be confined to the formal circumstances referred to in paragraphs (a) and (b) of that Section.

I have attached hereunder a list of those witnesses who gave evidence to the Inquiry and the order in which they did so.

List of Witnesses who gave evidence in the Inquiry

John S Oliver, BSc PhD CChem FRSC, Reader in Forensic Medicine (Toxicology), the University of Glasgow (by Affidavit)

- Patricia Stevenson, Social Worker, Families for Children, Glasgow City Council Social Work, Centenary House, 100 Morrison Street, Glasgow
- Annette Riley, BSc (Hons) MB ChB, FRCPath, Consultant Pathologist, Royal Infirmary, Livilands, Stirling
- Colin Lang, Anaesthetist, Stirling Royal Infirmary, Livilands, Stirling
- James Russell Fleming, Prison Officer, HM Prison, Cornton Vale, Stirling
- Elaine Senga Corvi, Social Worker, HM Prison, Cornton Vale, Stirling
- Stewart Adair, Prison Officer, HM Prison, Cornton Vale, Stirling
- Derek William McLeod, Head of Operations, HM Prison, Cornton Vale, Stirling
- Senga Hill Stalker, Prison Officer, HM Prison, Cornton Vale, Stirling
- Ashley Elizabeth Keenan, 16 Lomond Crescent, Lochgelly, Fife
- Jane Denise Reid, c/o HM Prison, Cornton Vale, Stirling
- James Fleming, Prison Officer, HM Prison, Cornton Vale, Stirling
- Howard Brinley Sellick, Prison Officer, HM Prison, Cornton Vale, Stirling
- Easton Robertson, Prison Officer, HM Prison, Cornton Vale, Stirling
- Craig Lee Sayers, MB ChB MRC GP, HM Prison, Cornton Vale, Stirling
- Sadie McKay, Nurse, HM Prison, Cornton Vale, Stirling
- Stephen Swan, Governor, HM Prison, Cornton Vale, Stirling
- Neil Summers Brown, Detective Sergeant, Central Scotland Police, Identification Bureau, Police Headquarters, Stirling.